EnCompass NUTRITION

Self-Pay Financial Agreement Form

The following is a financial agreement between you and Encompass Nutrition LLC that states your rights and financial responsibility as a self-pay customer.

I will be paying for my services directly because (please initial one):

_____I have chosen to opt out of utilizing my existing medical insurance coverage for this service. I understand that by choosing this option I forgo the ability to submit a claim directly to my existing insurance provider for the service and understand that Encompass Nutrition will not retroactively submit a claim to an insurance provider for services rendered.

_____I currently do not have insurance coverage. I understand that Encompass Nutrition will not retroactively submit a claim to an insurance provider for services rendered.

As a self-pay customer, I have the right to request that any medical records generated as result of today's visit NOT be disclosed for present or future commercial insurance plan(s).

Please initial one:

_____ Encompass Nutrition **may** share my medical record/treatment with a health insurance plan.

_____ Encompass Nutrition **may not** share my medical record/treatment with a health insurance plan.

The services scheduled for typical visits will cost approximately $140 for 50 minutes. The initial visit is billed at $205 for up to 75 minutes, $250 for up to 90 minutes. This is an *estimated* cost; the actual cost may vary depending upon the actual services provided.

I understand, as a self-pay customer, I may pay the estimated charges via cash, personal check or credit card.

If paying by credit card or debit card, I authorized Encompass Nutrition to charge my credit card or debit card for any additional services injured during my office visit, unless other arrangements have been made.

I understand that if a personal check(s) I have written is returned by my bank I will be responsible to pay the amount of return check within 10 days of receipt of notice from Encompass Nutrition.

If additional payments must be made after services are provided, I may call 303-949-1177 to pay by phone.

AUTHORIZATION

By signing below, I confirm that I understand the terms of this agreement and understand that I am completely responsible for any and all costs associated for all services provided to me, my dependents or any other person for whom I have assumed financial liability.

Patient Name (Printed): _____ DOB: _____

Printed Name of Responsible Party: _____

Signature of Patient/Responsible Party: _____ Date: _____